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Linacre Quarterly

n Anniversary

5 NOVEMBER, 1958 NO. 4

A Journal of the Philosophy and Ethics of Medical Practice

OFFICIAL JOURNAL OF THE

Federation of Catholic Physicians' Guilds

FEDERATION OF CATHOLIC PHYSICIANS' GUILDS

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The Federation of Catholic Physicians' Guilds

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OFFICIAL JOURNAL

NOVEMBER, 1958

VOLUME 25 NUMBER 4

In this Issue . . . . .

THE LINACRE QUARTERLY is the official journal of the Federation of Catholic Physicians' Guilds and appears February, May, August, and November. Manuscripts and news items should be directed to the Editor. Correspondence concerning advertising, subscriptions and other business matters should be addressed to the Executive Secretary, M. R. Kneifl.

Regular subscription rate is $2.00 a year, or 50c for the individual issue. Remittances for subscriptions and other business transactions should be made payable to **THE LINACRE QUARTERLY.**

Subscriptions to **THE LINACRE QUARTERLY.** for members of the various affiliated Guilds defrayed from membership dues are arranged by the officers of the respective Guilds.

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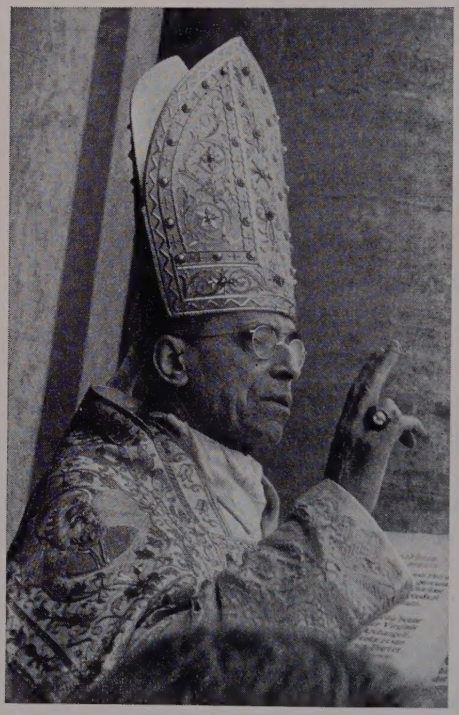
Entered as Second Class Matter at the Post Office at St. Louis, Missouri.

POPE PIUS XII



A SUCCESSOR to Pope Pius XII has been named as this is read, but warm in our memory is the recollection of this great Pontiff, and these words were written at the moment when hearts were saddened and a tear shed as at the death of a friend.

History will determine which of his many works contributed most to the welfare of the Church and mankind. The entire world mourned his passing because *all* people were close to his heart. Sympathy, compassion, and love were in his greeting to all within his sight as the familiar figure in white, with arms flung wide, would welcome the crowds wherever they gathered to hear him and receive his blessing.

More than ten million people were received in audience during his reign as Pope. A thousand discourses were given on almost as many subjects.

Our personal loss is tremendous. Many of his words found their way to the pages of this journal. Our moral theologians were guided by his wisdom in many of their contributions. Commentaries on his allocutions have been included and at times, when it was deemed expedient, an entire discourse has been the most important article of an issue.

His great concern for the sick and those serving the suffering will be a cherished memory in recalling his life. The medical profession was dear to his heart and his encouragement to those practicing in this field was a source of great benediction.

Leaders of the world in many endeavors have praised him beyond any phrases we could add. As Our Lord told His people, "I will not leave you alone," so Pope Pius XII did not leave us without guidance. His many documents, letters, and pronouncements will be preserved for us as part of our Roman Catholic heritage.

He wanted to be known as the "Pope of Peace." That for which he so ardently strove on earth must now be his for eternity. Heaven's brightest star must have shown its best when the soul of Pius XII came home to rest. His name will shine with great brightness in the world he just left, laboring so diligently to the very end for the well-being and happiness of all mankind. He worked and prayed to bring us closer to God. As a loving father he did this for his children.

May the day come soon when Pope Pius XII will be enshrined on the altars of the Church, along with Saint Pius X, whose sainthood he declared so recently. May it be the will of God as it is most certainly the will of the people.

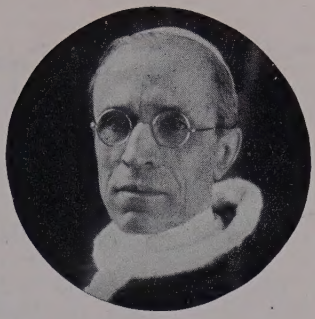
We rejoice that our lives have been touched with the greatness of Pope Pius XII.

THE EDITORS, THE LINACRE QUARTERLY

THE POPE OF MEDICINE

†

May His Great Soul Rest in Peace



The following cables were sent to His Eminence Eugene Cardinal Tisserant, Dean, Sacred College of Cardinals, Vatican City:

THE CATHOLIC HOSPITALS OF THE UNITED STATES AND CANADA EXPRESS DEEPEST SORROW ON THE OCCASION OF THE DEATH OF POPE PIUS XII. HE WAS TRULY A FRIEND OF THE SICK AND MOST UNDERSTANDING OF HOSPITAL PERSONNEL. HE WILL BE PRAYERFULLY REMEMBERED BY ALL.

The Catholic Hospital Association

THE CATHOLIC NURSES OF THE UNITED STATES OF AMERICA PRAYERFULLY EXPRESS DEEPEST SORROW AT THE DEATH OF BELOVED POPE PIUS XII. OUR NATIONAL COUNCIL AND ALL NURSES EVERYWHERE TREASURE MANY PRECIOUS EVIDENCES OF HOLY FATHER'S PATERNAL INSPIRING INTEREST IN OUR WORK FOR GOD'S SICK.

National Council of Catholic Nurses

WE CATHOLIC DOCTORS OF UNITED STATES OF AMERICA EXPRESS PROFOUND SENSE OF SORROW ON DEATH OF THE POPE OF MEDICINE. NO PONTIFF IN HISTORY HAS SPOKEN WITH SUCH INFORMED AND UNDERSTANDING ELOQUENCE ON MEDICAL MATTERS AS THE BELOVED PIUS XII.

National Federation of Catholic Physicians' Guilds

All cables were promptly acknowledged. For lack of space, we can include only that to the National Federation of Catholic Physicians' Guilds:

WARMLY APPRECIATING DEVOTED MESSAGE SYMPATHY OCCASION DEATH BELOVED HOLY FATHER POPE PIUS XII. I EXPRESS SINCERE GRATITUDE NAME SACRED COLLEGE CARDINALS.

CARDINAL ALOISI MASELLA CAMERLENGO

As you read this issue of our LINACRE QUARTERLY, the name of a new Pope will be on the lips of the whole world. I am sure your prayers as well as mine will be with him now and forever.

We mourn, however, the loss of our beloved friend, "The Pope of Medicine." These simple words of mine contain a world of personal memories — seeing His Holiness when I was a student priest in Rome, he was then Cardinal Secretary of State — thrilling at the privilege of being a participant in many audiences. My personal feelings, cherished as they are, are relatively unimportant.

The following special article by our President, Doctor William J. Egan, gives a beautiful message from a doctor to doctors on the abiding interest of the late Pope in all medical matters.

I should like to close this short letter to you by quoting the touching words of Archbishop Cushing of Boston on the occasion of the Pope's death: "In the tears and prayers of millions, he will live as long as sanctity, goodness, kindness, and love have meaning among men — and beyond that in the arms of God Whom he served with heroic dedication. May he rest in peace.

(Rt. Rev.) Donald A. McGowan

PIUS XII: THE POPE OF MEDICINE

WILLIAM J. EGAN, M.D.
PRESIDENT
NATIONAL FEDERATION OF CATHOLIC PHYSICIANS' GUILDS

Pius XII — The Pope of Peace, the Pope of the People, the Modern Pope, the Pope of International Diplomacy—we could multiply well merited titles almost endlessly. To us Catholic doctors, however, and indeed to all doctors, he is the Pope of Medicine. No Pope in history has spoken so often and with such understanding eloquence on matters medical. On more than thirty occasions in the past decade, he counselled physicians directly on their rights and duties to themselves, to their patients and to the community at large. His frequent counsels and directives gave abundant evidence of the universality of his interest as Vicar of Christ on earth and his particular concern for the guardians of God's sick and ailing creatures.

In his pronouncements, he typified the attributes of a true physician: knowledge, sympathy and understanding, and the faculty to teach, counsel and direct. Excepting Sir William Osler, the medical profession has been at a loss for more than a century for such direction. In the void, medicine has strayed and assumed alien rights that reached colossal catastrophe in the mass experiments of the Third Reich. Pope Pius XII spoke forthrightly as the "interpreter of the moral conscience of the research worker" and the director of the physician "whose duty is to cure and aid — not to harm or kill."

The vast knowledge of His Holiness was demonstrated every time he talked to doctors and others directly or indirectly connected with health care. Of his address to a special meeting of cardiologists, the eminent Doctor Paul Dudley White said: "One of the best papers on coronary heart disease I have ever heard." He proved his knowledge of highly technological problems when speaking to a group of roentgenologists he referred to the "simple question of the heat to be eliminated in the generators of the x-ray," the "revolving anticathode of the tube" and varying vulnerability of tissues to the "bombardment of infinitely small particles of extreme velocity."

Even fellow physicians do not commonly share with the ophthalmologists the knowledge of the corneal transplant operation that Pope Pius XII described so accurately. So accurately, in fact, that he was able to correct terminology then in common usage; and in so doing, give guidance to personnel of eye banks in the proper respect for the dead and the positive right to obtain material for transplant.

In greeting the anesthetists, he outlined their history from the unheralded nitrous oxide experiment of Horace Wells in 1845 through today's modern hypothermia for cardiac surgery. He gave specific directions on the rights of a patient to be relieved of pain, to accept pain for higher religious motives, but never for the sake of suffering itself, and he emphasized the rights of the dying to narcosis (alleviation of suffering through ethical use of drugs).

Again, in his addresses on cancer, on polio, and on A.B.C. warfare, the knowledge of an expert in each field shone through. One might well conclude that such comprehension contained in the person of one human being could only be a gift of the Holy Ghost.

Turning now to the second facet of a medical personality, as exemplified by His Holiness, i.e. sympathy and understanding, His Holiness repeatedly referred to the sick, the suffering, and the tormented. During the Marian Year, the Pope gave a special radio talk to the sick of the Diocese of Rome in which He said "How We long to pass in the midst of you, drying tears, bringing comfort, healing wounds, giving back again strength and health." In consoling compassion he added: "But the sick are precious jewels of the Church and powerful sources of spiritual energy. They can find correction and expiation, tempering and purification and the opportunity for the salvation of

souls by example, by faith, — and on the day of judgment you will at last see to what extent the world of the healthy is your debtor."

Again, in the Apostolate of the Sick and Suffering he said, "We would like to share your worries and sorrows, bring a little peace to your mind." He admonished that the sick are not, as the short-sighted superficial world sees them, alone and useless; but rather, close to Jesus and useful in the offering of their suffering in imitation, in example, and in atonement for the sins of others. How comforting both these addresses are to the patient immobilized by invalidism or terminal illness!

To the pharmacists and their alliance to the medical profession, he again showed his understanding in these words, "You lack the consolation that lightens the bitter tasks of doctors and nurses — the sight of an ailing patient recovering health."

To the nurses he said, "Your profession presupposes qualities out of the ordinary: a solid training, that is, technical knowledge thoroughly acquired and constantly kept up to date; a nimbleness of mind capable of continuously gleaning new ideas, applying new methods, using new instruments and medicines." He reminded them that they are the mothers of the sick as Our Blessed Lady, their model, is the Mother of all Mankind.

Addressing the World Congress on Fertility and Sterility, Pope Pius spoke of the "sad and painful" sacrifice of involuntary sterility. He commented on an increased birth rate as "the courage men show in the face of life with its risks and its difficulties."

Again, to the ophthalmologists he talked of the moral obligations due to a corpse as a result of the dignity it once possessed because it did house a soul and the kindness that must be tendered to the next of kin of the deceased.

His talks on natural painless childbirth, parenthood and marriage, moral and psychological problems occasioned by polio, are only a few additional examples of his abiding sympathy for and understanding of medical problems and especially the individuals plagued by them. Further evidence that he was the Pope of Medicine.

The faculty of teaching was another area in which Pope Pius XII excelled; talking on medicine to the International Congress of Medical History, he stated: "the doctor, whether he wishes to or not, must take a stand on human destiny. If he acknowledges nothing outside of biochemical phenomena, does he not, by implication, admit the failure of all his efforts. This position is neither acceptable to man's conscience nor is it in keeping with the spirit which inspired the long advance in medicine through the ages." Then, before the Latin Medical Union he gave a definition of the acceptable working norm of a doctor which entitles the profession to the dignity and nobility it enjoys. Here he said: "a patient is entitled to every consideration because he reflects the image of God. Any service which is rendered . . . is offered not alone to a man who is weak and unable to help himself but also to the Lord of All Creation. It is for this reason, the moral norms to which a doctor owes obedience go far beyond the prescriptions of a professional code of honor, they are . . . equivalent to a personal attitude towards a living God."

Thus establishing the basic tenet of a vocation in medicine Pius, at every opportunity presented, enunciated in no uncertain terms that the physician is "subject to the same broad moral and judicial principles that govern other men." He advocated an International Code of Ethics founded on three basic ideas:

"1. Medical Ethics should be based on being and nature
2. Should conform to reason and finality
3. Should be rooted in the transcendental (Higher Authority)."

He added that moral duty is not subjective and dependent upon the pleasure of man but is objective and subject to Higher Authority. He further stressed that the doctor who does not know his moral obligations "must study into them." With this instruction he noted a glaring weakness in modern medical education which concentrates on the material aspects of science and pays little attention (except legally) to formal teaching of the rights and duties of the doctor to his patient.

The Holy Father in his frequent talks on medical matters was very specific. A few examples of his informed decisiveness on particular points are the following:

Artificial insemination, in or outside of marriage, is immoral and therefore wrong. It cannot be considered from a biological and medical point of view leaving out the integral natural act of the married partners. "To reduce the cohabitation of married persons and the conjugal act to a mere organic function for the transmission of the germ of life would be to convert

the domestic hearth, sanctuary of the family, into nothing more than a biological laboratory."

His Holiness said further: "One of the most harmful aberrations that has appeared in modern society with its pagan tendencies is . . .'Planned Parenthood'; at times it is promoted by persons and organizations who command respect because of their positions in other fields but who have taken a stand in this matter which must be condemned." In this same treatise he mentioned: "confusing people . . . with misleading evidence, questionable polls, and even falsified statements from some clerics."

In his address to midwives, he stated: "Every human being, even the infant in the maternal womb, has the right to life immediately from God. Therefore, there is no man, no human authority, no science, no medical, eugenic social, economic or moral indication which can show or give a valid juridical title for the direct, deliberate disposition of a human being."

The Holy Father admonished the psychiatrists in these words, "no purely psychological treatment will cure a genuine sense of guilt." "Psychotherapy can not counsel a patient to commit maternal sins." Further, he condemned the Pansexual Method by emphasizing that man is not free "to arouse in himself for therapeutic reasons each and every appetite of the sexual order."

In stressing the limitations of medical research, he told the 8th Congress of the World Medical Association: "Man does not exist for the community. The Community exists for man." He clarified that man cannot transmit to others rights to his own body that he does not possess and, therefore, experimentation to mutilation or to the dangerous risk is wrong.

Further unequivocal directives on health matters weave a complete tapestry that symbolizes the Pope's interest in those afflicted with physical and mental trials.

Another characteristic of a good physician, which we mentioned, is the responsibility of giving wise counsel. Many brilliant gems in the special crown of the Pope of Medicine reflect his deep love for all in the health field. In his address on the Hospital Apostolate, Pius XII cautioned against allowing a patient to fall into a "certain anonymity" and suggested that the goal was "to know how to think of others, to be able to take to them an interest and a deep love." On heart disease, he rephrased the cardiologist's usual recommendation: "You also must be ready because at an hour you do not expect, the 'Son of Man will come'." To the doctors treating cancer, he posed the two-fold question: "What do I expect to accomplish by therapeutic means? By pain relieving measures? What will be the benefit to the total person?" For the answers, Pius XII said: "Pure science is almost completely overshadowed by the factors of human understanding."

At another time, discussing Medical Law and Morality, he indicated "that Moral Law and Medical Law are distinct but need to support each other to avoid rigorism on the one side and individualism on the other." Further he warned that "when divorced from each other, juridic positivism results where morality is underemphasized and the law of political authority is considered valid." An example of this is the present day attitude of American courts toward a doctor's (professionally secret) office records.

On the question of large families, the Pope said, "the only way to protect the physical and moral health of the family and of society is the wholehearted obedience to the laws of nature. There is no system of eugenics that can improve on nature. History makes no mistake when it points to violation and abuse of the laws governing marriage and procreation as the primary cause of the decay of peoples. Demographic politics have failed because they have debased the dignity of the family and the person by placing them on the same plane as the lower species."

And on fertility, he warned that when the researcher applies his findings to man, it is impossible to ignore the repercussions which the proposed methods might have on the individual and his destiny.

His Holiness was constantly preoccupied by another of the attributes we mentioned above, namely, the faculty of direction. He never allowed any group to leave his presence without positive directions. To each he gave a charge and his charge was especially specific in the health field. A few examples follow:

In his address on the Apostolate of the Midwife he directed "Every profession brings with it a mission, the mission of putting into practice the teaching and intentions of the Creator and of aiding men to understand the justice and holiness of the Divine Plan."

Again, to the International Congress of Catholic Doctors, he stated: "Because you are Catholics does not mean that you practice a special type of medicine,

but you do have a particular way of considering your professional problems. The mentality of modern man leads him to search for breadth, unity and simplicity."

In his address on cancer, Pius XII noted that the Creator allowed powerful anomalies called cancer to operate as well as more serious anomalies called sin. In the battle against the latter he asks the provocative question: "How does it happen that so often there is lacking the intensity of application with which humanity seeks out and combats physical pain?"

Of painless childbirth, the Vicar of Christ suggested: "The Christian . . . when faced with a new scientific discovery is careful not to admire it unreservedly and not to use it with exaggerated haste."

To the delegates of the International Poliomyelitis Conference, the Holy Father gave exhortation to extend their influence from the domain of therapy to the domain of human problems, to a complete understanding of man and the spiritual conditions of his life.

And, finally, to the roentgenologists he gave that beautiful laudation: "The scholar who devotes himself to labor such as yours — in trying to know the inexhaustible riches of physical and living nature — discloses every day a bit more of the treasures placed by the Creator in His handiwork."

Such is the inspiring legacy of Pope Pius XII. In an era when socialistic tendencies reduced men to the subservience of the State, he reaffirmed the dignity of man; when pragmatism dictated subjective morality, he restated the objectivity of morality in its source, the Divine Creator; when eugenic theories advanced excuses to satisfy human selfishness, he delineated the error proposed to abort the Divine plan; when doctors in the newer discipline of psychiatry invaded the secrecy of the human heart and mind, he pronounced the intrusion into the sacred precincts of the confessional. No previous pontiff, no doctor in this century, has advanced such clear directives to the profession. Pius XII merits well the title "Pope of Medicine."

Pope Pius XII: Medical Allocutions

IVth International Congress of Doctors
September 29, 1949—AAS*—p. p. 557-561
Comment on Artificial Insemination

Italian Union of Midwives
October 29, 1951—AAS—p. p. 835-854
Comment on a) Abortion
b) Birth prevention
c) Sterilization
d) Periodic continence

Convention of the Sodality "Family First"
November 26, 1951—AAS—p. p. 851-860
Comment on a) Abortion
b) Attempt to save life of both mother and child

Vth International Congress of Psychotherapy and Psychology
April 13, 1953—AAS—p. p. 278-286

VIth International Congress of Microbiology
September 13, 1953—AAS—p. p. 666-671

Ist Latin Congress of Ophthalmology
June 12, 1953—AAS—p. p. 418-42

Ist International Symposium of Genetics
September 7, 1953—AAS—p. p. 596-607
Comment on a) Sterilization
b) Prohibition of marriage for eugenic or genetic reasons

XXVIth Congress of Urologists
October 8, 1953—AAS—p. p. 674 sq.
Comment on a) Diceity of mutilation
b) Impotency

XVIth Congress of Military Medicine
October 15, 1953—AAS—p. p. 744-754

IIIrd International Congress on Poliomyelitis
September 11, 1954—p. p. 533-536

Congress of Medical Radiology
April 4, 1954—AAS—p. p. 214-218

Congress of The History of the Art of Medicaments
September 11, 1954—AAS—p. p. 536-540

XIVth International Congress of The History of the Art of Medicine
September 17, 1954—AAS—p. p. 557-580

VIIIth Congress of World Society of Doctors
September 30, 1954—AAS—p. p. 587-598
Comment on a) Experimentation on Living Man
b) Principles on which moral aspects of Medicine are based

IVth International Congress of The Latin Medical Union
April 7, 1955—AAS—p. p. 275-281

To The Doctors of Naples
November 11, 1955—AAS—p. p. 829-833

To Those Who Teach Obstetrics and Gynecology
January 8, 1956—AAS—p. p. 82-93
Comment on—Natural Childbirth

Congress of Doctors Who Contributed to Symposium on Coronary Arteries
May 8, 1956—AAS—p. p. 454-459

Italian Union of The Blind
May 14, 1956—AAS—p. p. 459-467
Comment on—Corneal Transplants

World Congress on Fertility and Sterility
May 19, 1956—AAS—p. p. 467-475

XVIIIth Congress on Chemotherapy
October 6, 1956—AAS—p. p. 793 sq.
Comment on—Medical Therapy in re Humans

Italian Society of Anaesthesiology
February 24, 1957—AAS—p. p. 129 sq.

To Doctors in Administration and Teaching
November 27, 1957—AAS—p. p. 1027-1033

XIIth International Congress on Orthodontology
September 8, 1957—AAS—p. p. 849-853

Morality and Applied Psychology
Congress of Inf. Assn. of Applied Psychology—April 10, 1958

Plastic Surgery—October, 1958

ANCILLARY:

Nursing: A True and Sacred Ministry Oct. 2, 1953
The Spirit of Sickness Feb. 14, 1954
Pharmacy: An Ancient and Modern Art Sept. 11, 1954
Dietetics: and the Nation's Health Sept. 25, 1955
Cancer: A Medical and Social Problem Aug. 19, 1956
A Doctor's Prayer: May, 1957
The Apostolate of the Sick and Suffering Oct. 7, 1957
The Large Family July 20, 1958

* Acta Apostolicae Sedis. This is the official publication of the Holy See since 1909.

THE PROBLEM OF HEMOLYTIC DISEASE OF THE NEWBORN AND ITS MANAGEMENT IN A GENERAL HOSPITAL[1]

Martin O. Sacks, M.D., Attending Physician
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EDITOR'S NOTE: Since THE LINACRE QUARTERLY *professes to be "a journal of the philosophy and ethics of medical practice," it is not our policy to publish articles whose content is exclusively medical. To do so, we feel, would be to compete needlessly and ineffectually in an area already adequately covered by the scores of excellent medical journals available to any doctor. The distinctive service which we hope to provide for our readers lies rather in the sphere of medico-morality.*

Dr. Sacks' article, because of its immediate and obvious implications, qualifies in an eminent degree for this latter category. The first duty of every physician is to provide his patients with optimum medical care. Specifically in the field of hemolytic disease of the newborn, where infant life and health hang so precariously in the balance, techniques which substantially improve the likelihood of a live and healthy baby are as morally imperative as they are medically superior.

As explained in the final section of this article, The Catholic Hospital Association has already undertaken a unique project in the form of a cooperative immunoserological laboratory program. To the extent that the interest and cooperation of hospital staff members may be necessary to implement this program, it is to be hoped that our doctors will not be found wanting.

IN any hospital where an obstetrical population exists, the problem of hemolytic disease of the newborn is present. This is especially true where a significant percentage of this population consists of multiparous women. The following data from this hospital help to emphasize the importance of this problem. The figures are approximate to the nearest round number.

In a two year period, slightly more than 10,000 infants were delivered. Of these, 13% had Rh_o negative mothers. The 1,300 mothers in this group had 900 Rh_o positive children; 100 of these children had hemolytic disease of the newborn as evinced by a positive Coombs test. About half of these affected children required replacement transfusion. In other words, *a case of hemolytic disease of the newborn may be expected about one in every 100 deliveries, and half of these will require replacement transfusion.*

1 In this summary discussion of hemolytic disease of the newborn, it has been necessary to leave out much significant detailed information which belongs more properly in a textbook. For the salient information to help put in practice the discussion enclosed herein, the author recommends the following excellent reference books:

1. *Erythroblastosis Fetalis Including Exchange Transfusion Technic*, by Fred H. Allen, Jr., M.D. and Louis K. Diamond, M.D., published by Little, Brown and Company.
2. *Blood Transfusion in Clinical Medicine*, by P. L. Mollison, published by Charles C. Thomas.

A survey[1] done elsewhere shows that by the sixth pregnancy at least one out of every four Rh negative women will be sensitized to the Rh factor. This indicates that the greater the degree of multiparity in a given hospital population, the more cases of hemolytic disease of the newborn are to be expected.

If an adequate organization for the care of these patients is in existence in a hospital, and this organization can be set into motion with celerity, the mortality from this disease (or its terrible sequelae) can be reduced to 5% of cases. If the disease is not recognized early, or transportation to another hospital is necessary before treatment can be instituted, the mortality will rise sharply.

The fact that a mother has had an infant with severe hemolytic disease of the newborn does not prevent her from having subsequent children who may survive and be normal if adequate therapy is instituted in time. This is especially true if the husband is heterozygous for the offending antigen. We have in our records cases which fully substantiate this. One Rh negative mother was sensitized to the Rh factor by an intramuscular injection of blood given in childhood for measles prophylaxis. Her husband (we found subsequently) is heterozygous for this factor. Her first three infants were Rh negative. Her next three were all Rh positive; all had hemolytic disease of the newborn, and all three required replacement transfusion, surviving normally. Her seventh child was Rh negative. Her next pregnancy resulted in identical twins with hemolytic disease of the newborn. These were much premature but withstood the procedure of replacement transfusion well. Unfortunately both had primary pulmonary atelectasis, and expired of this 14 hours after birth.

Even if the husband is homozygous for the Rh factor, families may be large. One of our mothers who was sensitized to the Rh factor by transfusion in childhood has had four children, all with severe hemolytic disease of the newborn; all surviving normally after early replacement transfusion (within the first hour of life).

In summary it may be stated that hemolytic disease of the newborn is a serious problem in a hospital, but if an adequate warning system exists, and if adequate therapy is readily available, the problem is by no means insuperable.

THE MANAGEMENT OF HEMOLYTIC DISEASE OF THE NEWBORN

Much has been written on the treatment of hemolytic disease of the newborn and its serological complexities. The very number of these publications tends to repel anyone desiring to set up a system for managing this disease, in the absence of a specialized blood bank, obstetrical or pediatric staff.

Our hospital has a very active obstetrical service and consequently employs a large staff. After some years of trial and error, an approximation of the system described below has become routine.

[1] Clemens, K. and Walsh, R. J.: The Frequency of Immunization of Rh-Negative Women by Rh Antigens. Med. J. Australia, Oct. 30, 1954, p 707.

I. Responsibility of the obstetrical staff (i.e., all those who deliver babies).

Any prenatal patient is to be typed as to $Rh_0(D)$ factor. This is by far the most likely factor (90%) in which incompatibility between mother and child will result in hemolytic disease of the newborn. It is the *one* essential step to be done before the patient is admitted to the hospital. If any obstetrical patient is admitted to the hospital without this being ascertained and available on record, the patient should be typed on admission. In primigravidas, presence or absence of atypical isoantibody should be determined at the seventh month. In multiparas, a test for this should be done at the third month, and again at the seventh month for purpose of comparison of the levels, if present. The absence of antibody in the seventh month is no guarantee there will be no difficulty, but the presence of antibodies is a warning of probable difficulty. In the presence of antibody levels, more frequent samples for titration may be drawn subsequently to appraise changes, but these are not essential.

On admission to the hospital a red sticker or some similar attention-drawing mark is attached to the mother's chart. After delivery, a similar sticker is attached to the infant's chart.

II. Responsibility of the pediatric staff (i.e., those who take care of the newborn).

When the baby is born, cord blood is taken directly to the blood bank where it is typed for $Rh_0(D)$ factor and a Direct Coombs test is done. If the Direct Coombs test is negative, it is not likely that the baby has hemolytic disease of the newborn, and nothing further is done unless signs of this disease appear. If the Direct Coombs test is positive, other tests are done, since the baby has hemolytic disease. In Rh hemolytic disease of the newborn due to $Rh_0(D)$ sensitization, a word of warning is necessary. Occasionally the red blood cells of a severely affected infant appear to be $Rh_0(D)$ negative, while the Direct Coombs test is positive. This apparent inconsistency is due to a very heavy coating of the infant's red blood cells by anti $Rh_0(D)$ maternal antibody, which prevents the usually observed clumping of $Rh_0(D)$ cells by anti $Rh_0(D)$ test serum. In such cases the Direct Coombs test is more important. It is also possible for the Direct Coombs test to be positive in cases where the mother is $Rh_0(D)$ positive; in such case the blood factor involved is one other than $Rh_0(D)$.

If the Direct Coombs test is positive, replacement transfusion should be performed wherever any one of the following conditions is also encountered:

(a) Prematurity — The premature infant is far more susceptible to kernicterus than the full-term infant.

(b) A history of a previous sibling with severe hemolytic disease of the newborn.

(c) Clinical icterus within the first six hours of life (and most with clinical icterus within the first twelve hours). These infants almost always develop a high serum bilirubin level.

(d) Hemoglobin less than 14 gm./100 ml. at birth.

(e) Reticulocytosis over 10%, or marked erythroblastosis.

(f) Cord bilirubin over 5 mg./100 ml. serum.

(g) If spectrophotometric studies are to be had, elevated levels of heme pigments other than bilirubin will give an indication of severity of illness. These are not generally available.

(h) High maternal antibody titer (level).

The preceding rules appear to involve a great deal of laboratory work, time consuming and fatiguing to both doctor and patient. However, the entire tabulation may be condensed to the following statement:

In the presence of a positive Direct Coombs test and any other of the factors listed, replacement transfusion is the treatment of choice. It is the unusual case which will require more than one or two tests to classify it. Indeed, the milder the case, the more laboratory work and observation will be required.

If the infant has a positive Direct Coombs test with no other positive findings, the serum bilirubin level must be determined at four to eight hour intervals in order to determine the speed of rise. *A rise of serum bilirubin approaching one mg./hr. is an absolute in-*

dication for replacement transfusion. Under these circumstances, do not wait until the bilirubin rises to a given critical level. A serum bilirubin of 10 mg./100 ml. at twelve hours, or 15 mg./100 ml. at twenty-four hours is also an absolute indication. A level of 20 mg./100 ml. at any time is an indication for replacement transfusion.

The hemoglobin level should not be used as a test for the progression of this disease after birth. The bone marrow may produce (for the first day or two) enough red blood cells to maintain a constant hemoglobin level in the face of increasing red cell destruction, so that a maintained hemoglobin level leads to a false sense of security.

Hemolytic disease of the newborn due to antibodies other than $Rh_o(D)$ is more difficult to discover. To obtain compatible blood for replacement transfusion where the causative antigen of the hemolytic disease is unknown, it is necessary only to give blood compatible with the mother's serum. Compatibility determinations should be made using mother's serum and low titered Group O blood. Three methods of compatibility testing must be used together—the saline tube test, the high protein slide method, and the Indirect Anti-Human Globulin (Indirect Coombs) test.

In a recent study performed by one of the blood grouping laboratories[2], the following incidence of hemolytic disease of the newborn in infants of Rh positive mothers categorized according to the offending antigens are listed:

Antibody Specificity	*Number of Cases*
hr'(c)	16
rh''(E)	6
$rh^w(C^w)$	2
hr, and rh''	3
rh'(C)	1
Fy^a	1
hr''(e)	1
$Rh_o(D)$*	1
A or B	3
Total	*34*

* The mother in this instance was a Du variant.

The significant fact is that most of the above mothers had previously been transfused or were highly multiparous (i.e., 6 to 13 pregnancies). The maternal charts and the charts of infants born to mothers with such a history should also have an attention-drawing mark affixed to them and the same testing and observation exercised to protect these infants.

The first warning of disease usually noted in the nursery is manifested as an early icterus. For this reason nursery personnel should be indoctrinated with the need for the *immediate* reporting of observed jaundice and to watch for its occurrence. Then, a Direct Coombs test, a complete blood count, and a serum bilirubin are done. Maternal serum should be tested for evidence of antibody. It may not be possible to demonstrate maternal antibody with the limited facilities of the average laboratory.

[2] Schlutz, C.: Hemolytic Disease of the Newborn in Rh-Positive Mothers. Bulletin American Association of Blood Banks, 2: 194-195, May 1958.

For example, if the ABO system is involved (and this diagnosis is frequently made with inadequate testing to eliminate the rarer antigen systems as culprits), the Direct Coombs test will usually be negative and the maternal serum will have antibody in every case, since it is present normally. *In any case, if no clear-cut serologic evidence of hemolytic disease of the newborn is found, the serum bilirubin level and its speed of rise is the sole criterion for performance of a replacement transfusion, and the critical levels are the same as those aforementioned.* In borderline cases, it is safer (if the operator is experienced) to do the replacement transfusion than to withhold therapy. In this way, practical, immediate therapy may proceed without definitive serologic diagnosis.

All sera in every case of hemolytic disease of the newborn (samples from mother and baby) should be sent to a blood center for detailed testing, confirmation of diagnosis, and definition of antigen system. This will check results of the hospital laboratory, add knowledge and experience in the disease, and occasionally supply a rare antiserum from the mother which may be used for research purposes. (It will also protect the mother from incompatible transfusions in the future, should she need any.)

Certain elements of the actual performance of the replacement transfusion remain to be discussed. It is safer not to warm the blood but rather to keep the patient warm. It is essential that the operator have an alternative technique available in the rare case where the umbilical vein cannot be catheterized. If the patient has hepatosplenomegaly, cardiac failure is probably present in some degree, and blood should be withdrawn until the venous pressure is about 7 cm. water; then the exchange of blood should be begun. Enough calcium (as 10% calcium gluconate) should be given at intervals (1 to 2 ml. for every 100 ml. blood used) to prevent hypocalcemia, which is manifested by irritability before tetany appears.

Insofar as aftercare is concerned, the child should be kept in a heated bed, and routine nursery feedings may be started after twenty-four hours. Serum bilirubin levels at four to eight hour intervals are done to ascertain whether a repeat replacement transfusion is needed; 20 mg./100 ml. serum is the critical level. As soon as this danger is passed, and the child is otherwise in satisfactory condition, it may be discharged. Thereafter, weekly hemoglobin and microhematocrit levels should be done. This is necessary to follow the progressive anemia which usually occurs in these infants. The faster the weight gain, the more precipitous the drop in hemoglobin. This is due to several factors: the bone marrow is temporarily exhausted and does not begin to form erythrocytes for several weeks after birth; the life of transferred cells is shorter than the infant's own; so that a gradually decreasing number of erythrocytes in an increasing body mass and circulating volume manifests itself as anemia. Any antibodies remain-

ing after replacement therapy may also add to the anemia by the destruction of any cells newly formed.

If the infant remains healthy, the drop in hemoglobin, even to 6 or 7 gm./100 ml. blood, does not constitute an emergency, but care should be taken to prevent infection. If the child shows evidence of illness in the presence of anemia, transfusion is necessary. If not, the anemia will usually begin to correct itself by six to eight weeks of life. If transfusion is necessary, it does not matter now whether Rh positive or Rh negative blood is used.

A COOPERATIVE IMMUNOSEROLOGICAL LABORATORY PROGRAM FOR THE CATHOLIC HOSPITAL ASSOCIATION[3]

The Catholic hospital has a moral obligation to seek out the most modern and scientific methods and to apply them to the proper care of its patients. Since there is no substitute for experience in this field of immunoserology, experience can be gained only by properly testing large numbers of blood samples. Small facilities rarely have enough well trained people or equipment to perform certain special tests, and only by cooperating with larger facilities can these tests be done accurately for them.

A cooperative program now exists which will permit such smaller Catholic hospitals to send laboratory specimens (if they are not at present equipped to examine them) to specially trained and equipped institutions which have been set up to perform these special procedures.

This program is in its first phase. An immunoserological training program to instruct members of religious communities to a very high degree of skill through "workshop" type meetings has been held. The religious, technicians and pathologists attended daily sessions of six hours each. Only fourteen laboratory persons, each from a different facility, were trained because it was felt that such a limitation permitted very close supervision of workers and resulted in higher levels of skill in the performance and understanding of the procedures involved.

A coordinating laboratory will now send unknown test samples to each facility. Successful identification and testing of these samples by the trainees working in their own laboratories will start another phase of the program; namely, invitation of "satellite" hospitals to send blood samples to these "qualified" laboratories for testing.

The laboratory procedures to be initiated are:

1. Maternal Rh sensitivity tests and titers.
2. Phenotyping or determination of heredity transmitting characteristics of the father.
3. Detection and identification of atypical antibodies.

[3] Schlutz, C. Institute for Applied Immunology, Cihcago, Ill.: Personal communication (A summary of an official program of the Medical Technology Committee of the Catholic Hospital Association of the United States and Canada).

4. Other special serodiagnostic and consultation services.
5. A serum exchange program.

Cooperation between the "qualified" laboratories and the hospitals expected to cooperate with them will be solicited by the Medical Technology Committee of The Catholic Hospital Association by a request to the administrator of each hospital asking for such cooperation in sending blood samples to the "qualified" laboratories for testing. The "qualified" laboratories will eventually instruct "satellite" hospitals in recommended procedures for Rh, blood grouping, and compatibility tests so that the physician can be assured that his hospital will be set up to provide the maximum scientific training and experience for the needs of his patients, and that only experienced and informed personnel will be performing vital immunoserological tests.

NOTE: Because most hospitals will have fewer than twenty cases of hemolytic disease of the newborn in a year, it would be better if a few members of the medical staff agreed in advance to care for these patients when the need arose. Thus, one man would always be available, and the experience needed for the acquisition of technical skill would not be spread too thinly among too many people.

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A CLOSED RETREAT

Its Value for Physicians

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"Come to Me, all you that labour, and are burdened, and I will refresh you." (Matt. 11:28). These words of Christ are impelling and refreshing, and are a timeless source of abundant spiritual and physical good among multitudes of souls.

A well-established purpose of the Retreat Movement for Catholic Laymen is to foster these refreshing words of Christ in such a way that they provide a realistic source of spiritual enrichment and personal enlightenment for the Catholic individual. This long-standing work of the retreat movement is of great importance and significance. It provides the lay apostolate with extraordinary means for perfecting spiritual and moral virtues and for furthering fundamental principles of Christian life and thought which strongly augment underlying forces of continuing Catholic lay action.

The retreat movement is a rapidly growing custom in the United States, and it has achieved remarkably well one of the special desires of Pope Leo XIII, who recognized with extreme insight the need for all human subjects "to retire a little while and turn their thoughts from the earth to better things." In some states and areas the practice of "making retreat" is comparatively new. It has become increasingly popular however, and has proved to be a source of generous spiritual and physical benefit, and thereby an important source of unusual power for the lay apostolate.

The purpose of this paper is to point out that "making a retreat" is one of the most unusual means of providing for a person a type of experience that not only deepens his religious conviction and fosters a spiritual way of life but also achieves a state of natural physical and mental rest.

These unique benefits of retreat are extremely impressive and are largely responsible for the increasing personal interest of innumerable Catholic physicians in the retreat movement. There are many reasons why this is so. Situations that occur in a physician's life often serve to create real reasons for establishing the practice of making a retreat regularly. This life is both complex and busy, and not infrequently overly strenuous.

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Exposure to many separate environmental forces tends to disturb what is otherwise a reasonably satisfactory balance between man's body, mind and soul. Frequently, continuing demands on his time and matters requiring careful decision and action highlight a physician's teeming professional and personal life. There is the simple situation of trying to grasp details of knowledge of a patient's complex illness while conscious of the demands for his presence elsewhere — the telephone calls of colleagues, the bedside of a seriously ill patient, the schedule of surgery in the hospital and the meeting of a medical, civic, church or school committee. Efficient means of modern communication also load a physician with appreciably more problems than he can reasonably carry into practice. The ordinary expenses of existence and even the less evident pressures of social, political and cultural effects steadily increase and substantially effect stressing influences on a person.

The results of these continuing influences serve to emphasize the physician's pressing struggle to carry out at times a manner of living that is intimately designed to be pleasing to God and basically rewarding to his patients and associates, and to members of his family.

As notable as these aims are, a physician's mode of living often accounts for his steady loss of awareness of the commonly felt effects of strain. His responses to the ever increasing demands of each individual and by every group of human beings to whom he is both normally and decidedly devoted may be noticeably less effective and less thorough. Unimportant annoyances and frustrations, and even temptations of special pleasure and personal advantage heretofore controlled adequately with modest effort, oftentimes assume a role of jumbled significance and false importance. Not only may he gradually lose sight of the usefulness of prayer and frequent meditation, but also the measureless value of the sacrament of penance and gifts of Holy Communion may be ignored with increasing frequency.

Since the physiological effects of sustained psychological and physical fatigue often evolve insidiously, even a so-called sensible and scientifically trained human being, such as a doctor of medicine, may become frequently and unexplainably bewildered. Biological reactions of continuous stress and fatigue differ widely in individuals, however, and many separate factors play diverse roles of importance in the total make-up of each human being. The type of physical and psychological endowment, the difficulty of carrying out a standard of excellence in medical practice, the degree of gravity of conflict in his family and social group, the economical aims and the caliber of professional relations all serve to influence the physician's extent of vulnerability to the ordinary stresses of a busy professional and personal life.

When basic causes for physical reactions of continuous fatigue are permitted to continue, however, there occurs a diminishing ability to concentrate and to think, and

increasing inability to cope satisfactorily with controversy. Once lofty goals of the physician's personal life and auspicious vocation appear less and less cherished, with further disregard for real prayer and for frequentation of the Sacraments; and what was at one time a frequent and ardent participation in Holy Mass may become decidedly less evident.

Some of the manifestations of psychological and physical reactions, together with a clear-cut state of mental depression and anxiety, are also brought about by the nagging reproaches of conscience and the awareness of gradually losing one's soul. A state of anxiety and depression is also largely responsible for the physician experiencing a strong desire "to wipe out" all undesirable feelings with special therapeutic measures which would provide a sense of sustained tranquility and "peace of mind." All too often this means for some physicians the little stressed start and the unwarranted continuing use of different pharmacological means. Sedative and stimulating compounds, alcoholic liquors, tranquilizer agents and narcotic drugs, which obviously afford convincing, but temporary, feelings of false "well being" only serve to compound unfavorable problems of far reaching consequence when used over and over again.

With proper foreknowledge and resourcefulness most physicians abort "gloomy" events such as these. An innate endowment of superior intelligence and a state of emotional stability, which are supposed to be characteristic of a physician's constitutional make-up, should be useful advantages. Most physicians organize properly some of their daily activities, partake frequently of well-recognized benefits of physical exercise (golfing, fishing, swimming, bicycling, etc.) and provide regular periods for short diversions of "free time" from a busy professional practice.

In a state of abundant privileges and remarkable scientific accomplishments, however, which provide many modern means for functioning efficiently and normally, an extremely successful physician may "have everything he needs" except one of the most important — time to think and time to set his life and soul in order. A period of solitude is essential, and this ever increasing need is of profound importance.

Providing for one of the most pressing needs of physicians and laity alike is an indisputable advantage of retreat. Complete freedom from distraction and days of ample time for solitude and devout quiet furnish a type of atmosphere that is both satisfying and relaxing. Proper physical relaxation is unquestionably essential for clarifying one's own thoughts and for reaffirming personal goals and objectives. Indeed, the special environment of retreat compels a person to "take stock" of himself.

Proper time in retreat is allotted not only for contemplation and for spiritual reading, but also to regularly scheduled religious conferences. Conducted by a re-

treat master possessing superb ability and unusual insight, the conferences embrace a number of topics of special value and significance. Remarkable awareness of the reasons for a person's doubts and anxieties, and their influences, is especially evident and strong emphasis is given to the ever important power of frequent prayer for controlling one's thoughts, feelings and compulsions. Wise religious counseling which is always available privately, permits opportunity for special consultation for working out possible solutions to some of the complicated moral and ethical problems which a person might have.

These activities of retreat are a notable source of good for many physicians. His capability for understanding more deeply the problems of other people may be appreciably enhanced. Thus, in a positive way he furthers his ability to guide with compassion some of the human subjects in his practice and own profession, especially those who are possessed by disorders of anxiety, fear and insecurity, and by less evident disturbances of perverted ethics and logic.

A professional man devotes much of his life to a search for so-called scientific facts and for more effective methods of improving means for diagnosis and treatment. It is not out of place, and certainly not unfashionable, for him periodically to take the time to stress fundamental tenets of faith and to utilize means that increase with certainly the depth of his faith and inner perfection and the breadth of his moral perspective.

Both the unusual religious experiences and the strong intellectual forces of retreat stimulate a person in this regard. By increasing his knowledge of basic tenets of reason and the special virtues of faith and charity which underlie the vast knowledge of Catholic morality, the physician also enriches his respect for the fundamental Christian principles of morality and ethics. Since these well established principles dominate basic concepts of proper medical ethics and standards of excellence of practice, any opportunity to enlighten one's moral wisdom and soundness, perhaps to a degree paralleling or surpassing ever-increasing scientific knowledge, should be of real concern to a physician and his science and practice of medicine.

The extraordinary circumstances of days in retreat, however, are those that serve to acquire for the individual a greater recognition for the dignity of his soul and its proper stature in relation to God. *This provides man incalculable good.* The frequent opportunity for exposure to the special benefits of penance and the supernatural gifts of intimate contact with the Blessed Sacrament serve abundantly to permit a physician to grow in the knowledge and understanding of the will of God.

The noteworthy increase of faith and the spiritual reinforcement of grace beget a type of physical and mental buoyancy that is of distinct usefulness to man's intellectual fa-

cilities and physical well-being. Indeed, the physician can leave closed retreat enriched and enlightened by the grace of God, and carry out with extreme freedom of will and intelligent reason a harmonious program of realistic peace with himself, with his vocation and with God.

Leonardo da Vinci, who excelled in almost every principle profession of his time, and who pursued varied interests with extreme success, recorded this advice in one of his notebooks: "Every now and then go away — for when you come back to your work your judgment will be surer, since to remain constantly at work will cause you to lose power of judgment."

His Holiness, Pope Pius XI, in his encyclical letter on Laymen's Retreats described inexpressibly some of the roles played by the properly timed retreat movement: "In these Exercises an opportunity is given to a man to get away for a few days from ordinary society and from strife and cares, and to pass the time, not in idleness, but in the consideration of those questions which are of perennial and profound interest to man, the question of his origin and his destiny, whence he comes and whither he goes . . . retreats are like so many Cenacles wherein courageous souls, strengthened by God's grace and following the teaching of eternal truth and the prompting of Christ's example, not only perceive the value of souls, not only conceive the desire of helping souls (in proportion to each one's vocation), but also learn the ideals, the dreams and the boldness of the Christian apostolate. . . . We hold it for certain that in the growth of this work lies the most powerful support against growing evils."

The Impediment of Impotency and The Condition of Male Impotence

A Canonical-Medical Study

Rev. Paul V. Harrington, J.C.L. and Charles J. E. Kickham, M.D,. F.A.C.S.

To present the problems involved in the matter of male impotence as related to the validity of marriage, here follows the second part (Part I, August 1958, THE LINACRE QUARTERLY) of the canonical considerations as prepared by Rev. Paul V. Harrington, J.C.L., canonist of the Archdiocese of Boston. The medical study as set forth by Dr. Charles J. B. Kickham will appear in the February 1959 issue of this journal.

PART II

CANONICAL CONSIDERATIONS

The above represents the development of the concept of an impotent condition and the requirements for potency which were commonly held at the time of the promulgation of the Code of Canon Law in 1918. It remains now to consider the opinions advanced on this subject by the canonists and theologians, who have written during the past forty years and to study the decisions of the Sacred Roman Rota and the decrees of the Roman Congregations, which have been issued during this same period.

The several writers of this period are careful to distinguish between the concept of impotency and that of sterility. An impotent person is considered to be one who is not capable of having true conjugal relations; whereas a sterile person is thought to be one who, although he can have normal, satisfactory marital relations, is unable to generate offspring because of the presence of some complicating condition, which rules out this possibility.

The specific definitions of the term *impotency*, as given by various authors, are interesting to consider.

Cappello states that impotency is the inability of a man or woman to have conjugal copula or the inability to participate in conjugal copula or the incapacity of depositing, in a natural manner, *verum semen* in the female vagina. This same writer continues by saying that potency includes also the notion that the concupiscence of a man or a woman be satiated in a legitimate and natural way which is accomplished by penetration and semination within the vagina. Inchoate or attempted penetration does not suffice because this increases and irritates concupiscence rather than satisfies it.

Chelodi-Ciprotti refers to impotency as the inability to have

copula, which is *de se* apt for the generation of offspring.

Gasparri refers to and quotes the definition of Antonelli: "Impotency is the absolute and necessary inability to obtain offspring because of the lack of organs essential to generation or because of their atrophy or because of any other defect which renders copula either impossible or, by its nature, necessarily sterile."

Noldin cites the opinion of one group, including Antonelli, Bucceroni, Wernz, Santi, Leitner and Lehmkuhl, to the effect that an act of ordinated copula is required but in addition, *verum semen,* on the part of the man, and an ovum, on the part of the woman, are required, thus reducing impotency to an inability to generate rather than to an incapacity to copulate. He also mentions a similar theory that required, in addition to the ordinated act, that the man deposit *verum semen,* although there was no ovum or could not be any ovum on the part of the woman, because the ovaries had been excised. The followers of this opinion described *verum semen* as that fluid which is elaborated in the testicles even though it be devoid of live sperm and not merely the fluid which is produced by the seminal vesicles or bulbo-urethral glands. Finally, Noldin mentioned his own definition of impotency, as shared by others, as merely an incapacity to copulate and hastened to state that this follows the tradition of the older authors, which was upset for some time after the 16th century because of an improper understanding of the text of Pope Sixtus V. Noldin and others held that a marriage was valid and could be contracted provided even some of the secondary ends could be obtained and added that sedation of concupiscence and the communication of mutual love could be achieved by any satiative copula even though there was no semen or ovum present.

It is clear from the above that the authors who defined potency in terms of generation and conception and required *verum semen* on the part of the man and an ovum on the part of the woman were most likely confusing impotency with sterility and potency with fecundity. This confusion arose because the basic distinction between the *Actio Humana* and the *Actio Naturae* was not properly understood. The former, more properly referred to as conjugal copula, consists in the penetration of the vagina by the male member and the effusion therein of *verum semen. The latter,* which concerns the female only, consists in the passage of the sperm to the inside, the descent of the ovum through the fallopian tubes, the fertilization of the mature ovum, the development of the fetus wthin the uterus and the birth of the child.

It is obvious that the human action, as described above, is the only action over which the individual has control and for which he can be judged responsible and thus this is the only action that can be made the object of the marriage contract. Therefore, it follows that potency or impotency must be considered in terms of the ability or inability to perform the human action without any reference being made to the action of

nature which follows, provided there is no complicating pathology or abnormality which would rule out generation.

Since generation depends upon the hidden processes of nature and not on the individual, as individual, the action of nature, which is beyond human control, cannot be the object of the marriage contract and thus it cannot be part of the definition of the conjugal act. Because the action of nature cannot and does not enter into the definition of the conjugal act, neither can it be introduced into the definition of potency or impotency.

Also, the section of the Code of Canon Law, referring to marital consent, tended to continue the confusion by stating that the object of the marital contract, for which consent was given, was "an act *per se* apt for the procreation of offspring."

Cappello prefers to define the conjugal act as "that action by which *verum semen* is deposited in a natural manner within the vagina of the woman." Because reference to all generation, actual and potential, is excluded in the latter definition, there can be no confusion between sterility and impotency.

Conjugal copula, according to a decision of the Sacred Roman Rota, is that act "by which the spouses become one flesh and the marriage is consummated." Canon 1015 §1 of the Code of Canon Law states that a marriage is consummated "if between the spouses there takes place the conjugal act to which, by its very nature, the marital contract is ordinated and by which the spouses become one flesh." St. Thomas indicates that spouses become one flesh when the members or organs of the one are made the members and organs of the other.

Thus, the terms conjugal copula, consummation, becoming one flesh are all made equivalent and impotency becomes the inability to have successful conjugal copula, properly to consummate a marriage or to become one flesh with one's spouse. It is evident that no one of these terms specifically or essentially contains within it a direct reference to generation even though the marital act is ordinated to a generative purpose.

As stated previously, conjugal copula is that human action whereby, in a natural manner, the female vagina is penetrated by the male organ and semination occurs therein. This composite act is constituted by three separate operations: erection of the penis, penetration of the vagina and semination within the vagina. These multiple operations required, on the part of a man, a normal penis, which was capable of being erected and sustained in erection until penetration was accomplished; at least one healthy, functioning testicle and the ability to deposit *verum semen* within the vagina.

The Supreme Sacred Congregation of the Holy Office on March 1, 1941 declared that for perfect copula and consummation of a marriage it is required and suffices that "a man, in some fashion, even though imperfectly, penetrates the vagina and immedi-

ately effects, in a natural manner, a semination, at least partial, within the vagina, with this reservation that the entire male organ need not enter the vagina."

Harrington and Doyle, in an article in the LINACRE QUARTERLY of August, 1952, concluded: "This, the minimum, which is required and suffices for true consummation, is to be found between the two extremes of mere vulvar penetration, on the one hand, and complete penetration of the entire male organ, on the other. There must be verified a true entrance through the hymeneal membrane and into the vaginal canal, so that part of the male organ can be truly said to be enveloped by the vagina. Juxtaposition of the glans penis against the hymeneal orifice with the result that only the tip of the glans enters beyond the hymeneal membrane, and this without in any way stretching or tearing it or loosening the hymeneal ring, is not sufficient. For, in this instance, it could not be said that any penetration had occurred. Rather must there be realized the apposition of an erect male organ against the hymeneal orifice with a definite pressure which will cause the membrane to be pushed aside and to be stretched, at least momentarily, so that part of the male organ can actually enter the vagina. This minimum penetration, coupled with simultaneous semination, will constitute proper consummation."

Both the penetration and insemination must be intravaginal. This requirement immediately rules out artificial semination, whether the semen is procured directly from the epididymis of the husband or obtained in any other way and then injected into the vagina or uterus without any type of marital relationship having been effected and it also excludes mere semination *ad os vaginae*. Gasparri stated that if a child was conceived by mere semination *ad os vaginae*, it is to be said that he was born from non-matrimonial coitus and from impotent parents.

It is possible for actual conceptions to occur without a marriage being canonically consummated and even when one of the parties is canonically impotent. To substantiate this conclusion, reference is made to two decisions of the S.R. Rota, wherein a definite judgment was made that marriages had not been properly consummated even though the fact of conception was beyond all controversy and in a particular case, even though a woman had given birth to two children, for in this instance, it was verified that the subject was suffering from such severe vaginismus that penetration was impossible.

Thus, whatever would prevent a man from penetrating or from seminating within the vagina or a woman from being penetrated could be the cause and basis of impotency.

In considering male impotency, due consideration must be given to the basic distinction between organic, anatomical, mechanical, instrumental or constitutional impotency, on the one hand, which refers to the lack or ineptness of copulatory organs or to some defect or lesion, which effects them

and, functional impotency, on the other hand, which arises from various diseases of the nervous system or lack of proper stimulus which prevents the normal functioning of the male sexual organs. The greater part of the subsequent pages will deal primarily with problems of organic impotency.

At first, consideration will be given to those male deficiencies which all canonists and theologians unanimously agree constitute a definite condition of impotency and only after these have been described and considered will attention be given to the remaining anomalies which provide the basis for much dispute and controversy.

It must be recalled that in order for an impotent condition to constitute the diriment impediment of impotency and prevent a marriage to be contracted or invalidate a marriage already contracted, it must be antecedent to the contracting of the marriage and permanent, according to the understanding of these elements as discussed in a previous section.

All authors agree that if a man lacks a penis, either because he was born without one or it was surgically removed at a later date, or if the penis is infantile or rudimentary in size or excessively large, and thereby prevents penetration, then an impotent condition is considered to be present.

If an individual suffers from hypospadias or epispadias, whereby the urethral canal opens not in the top of the penis but rather along the middle or at the base of the penis, and if, because of this anomaly, a *verum semen* cannot properly be deposited in the vagina, the person is adjudged to be impotent. One Rotal decision discusses this point at length, and sets forth that hypospadias has several forms depending on whether the urethral os lies below the glans penis or in some other part of a divided scrotom or opens behind the scrotum into the perineum. This decision continues by stating that in the case of scrotal hypospadias, if the penis is crooked, proper semination cannot be had. In perineal hpyospadias, semen is emitted but between the legs of the man without touching the external organs of the woman and thus, intra-vaginal semination cannot be accomplished. In the other forms of hypospadias, where the urethral canal opens along the penile shaft, each case must be investigated individually to determine whether or not proper semination can be effected. This decision concludes by pointing out that if semination is impossible in the usual position, it might be possible if the position were to be changed and quotes Cappello to the effect that if the usual position for coitus is changed or if other licit means are used and thereby semen can be deposited in the vagina, there is no impediment.

Conditions, affecting the erection of the penis are also possible causes of impotency and are listed by the authors as: absolute frigidity of the man, diseases of the center controlling erection, sexual neurasthenia, progressive spinal paralysis caused by a venereal infection, anaphrodisia, which prevents erection, aphrodisia, which causes too much venereal excite-

ment with consequent premature ejaculation, and sexual anaesthesia.

Authors wonder if a man is impotent who uses unaccustomed means, because of parathesia, to excite himself. Cappello answers that the man is certainly not impotent, if the means employed are licit in themselves. If the means are illicit and he can be aroused only by these illicit means, he is to be considered impotent but, in the opinion of experts, this type of condition is not of its nature permanent, can be cured by licit means and thus the impediment of impotency cannot be said to be present.

Up to the present, all canonists held that a man, to be considered potent, must possess, in addition to an erectible penis, at least one healthy, functioning testicle. Thus, they conclude that complete absence of both testicles, either congenital or by surgical removal, total atrophy of both testicles or undeveloped testicles would constitute an impotent condition and if this deficiency existed at the time of the marriage and was incurable, the invalidating impediment of impotency would exist. However, in trying to establish the complete absence of both testicles, one must take into account the possibility of the condition of cryptorchidism being present, wherein the testicles are undescended and are lodged in the abdomen or in the inquinal ring and thus cannot be readily observed.

Although all canonists have agreed on the necessity of one healthy, functioning testicle being present, they do not concur on the purpose that the testicle is to serve. One theory holds that the *verum semen,* required for intravaginal semination, should be manufactured in the testicles, and that this semen, with its testicular component, must pass unobstructed from the testicles through the deferent canals to the urethral orifice, from whence it is deposited within the vagina at the time of the marital relations.

The second theory would demand the presence of one healthy, functioning testicle not for reason of any semen that it might elaborate but for its endocrine function whereby the testicle releases androgen into the bloodstream, which, in turn, accounts for and regulates the libido of the individual and his consequent ability to attain and maintain an erection.

Neither theory requires the presence of a functioning testicle for its spermatogenic function since the presence or absence of spermatozoa refer to fertility or sterility and not to potency or impotency.

The juxtaposition of these two theories sets the stage for the current major controversy relative to the proper understanding of the term *verum semen* which, as mentioned previously, has been employed by all writers from the time of Pope Sixtus V but which has never been clearly defined or analyzed. All canonists and theologians have required some type of semination in order to have true marital copula but no one, until relatively recently, attempted to describe the composition and constitution of this semen. Thus, since

semination is required for potency and since it has not been clear exactly what constituted this semen, it is only natural to expect that some difficulties would arise in the understanding of an impotent condition and some controversies would develop as to the validity or nullity of certain marriages.

As previously indicated, Cardinal Gasparri, an eminent canonist, was the first writer to attempt to define *verum semen* and to locate the site of its production. In the third edition of his book, which appeared in 1903, while discussing the semen of old men and youths, quite by accident and incidentally, he described true semen as that which was manufactured in the testicles and thereby canonized the phrase which is so prevalent today in canonical literature *"semen elaboratum in testicals."* In this connection, he said "Although the semen in old men or youths is generally not fertile either because spermatozoa are lacking or are not sufficiently vigorous, nevertheless it is of the same constitution as true fertile semen, since it is established in its natural organs, namely the testicles."

As authority for this statement, Gasparri quotes the writings of Sanchez, who wrote his classical work on marriage shortly after the *"Cum Frequenter"* of Pope Sixtus V was issued.

Gasparri makes a second reference in this same edition to the nature of *verum semen*. He says "male semen is, as we have said, produced in the testicles. Hence castrates and eunuchs, who lack both testicles, are clearly and certainly incapable of emitting true semen as Sixtus V clearly teaches." It would appear from this passage that Gasparri believed Pope Sixtus V to have understood *verum semen* to be that which was manufactured by and in the testicles although the Supreme Pontiff did not define the term, because he offers no further proof or authority for his interpretation.

In 1911, Wernz, another outstanding commentator on canonical subjects, simply states, without any proof, that *verum semen* is that semen which is elaborated in the testicles. It would appear that he, as had Gasparri before him, had concluded that if eunuchs and others, who lacked both testicles, could not validly marry, the reason must be that the testicles, which they lacked, must produce some essential element that is required for true marital copula and it was because of this reasoning that he took it for granted that *verum semen* must be produced by the testicles. Such a conclusion is understandable when one reflects that in 1911 when he wrote, the spermatogenic function of testicles was known, but very little about their endocrinological function was appreciated.

The Sacred Roman Rota, quoting Gasparri and Wernz, has always interpreted *verum semen* as that which is elaborated in the testicles and has always insisted that, for true and perfect marital copula, the fluid, deposited in the vagina, must contain a testicular component and, therefore, that there be an uninterrupted and unobstructed channel from the testi-

cles to the os urethral. Thus, if a man lacked both testicles, either by reason of a congenital defect or by surgical intervention, or if both testicles were completely atrophied or undeveloped and thereby could not manufacture semen or if the semen, once elaborated, could not pass to the urethral orifices because both *vasa deferentia* were occluded, by reason of disease or sutured as a result of a double vasectomy, that man would be considered impotent and he would be estopped from contracting marriage or, a marriage already contracted, would be declared null and void, if the condition was proved to be antecedent and permanent.

Having adopted this particular interpretation in 1914, the Sacred Roman Rota has never changed its opinion and has, over the past forty years, set up a constant, consistent and unanimous jurisprudence, which all the present Judges of this august Tribunal have accepted. From 1914 through 1943, the Sacred Roman Rota judged 38 cases in which inability to emit or deposit semen, elaborated in the testicles, was the main issue and, in all cases, the above interpretation was invoked and in all but six cases, the marriages were declared invalid. In these remaining cases, the condition of impotency was established but the impediment of impotency could not be proved because there was question of the antecedent or permanent nature of the condition and in each instance the Holy Father dissolved the marriages on the basis that they were never properly consummated by true marital relations.

More important than the consistent jurisprudence of the Sacred Roman Rota is the fact that two Supreme Pontiffs, Pope Pius XI and Pope Pius XII, have actually dissolved six marriages on the ground of non-consummation, when it was proved that the husband was unable to emit and deposit semen that was elaborated in the testicles. Father Aguirre states that the Popes have used their power as Vicars of Christ indirectly to confirm the constant jurisprudence of the Sacred Roman Rota.

As indication that the Sacred Roman Rota still adheres to the classical interpretation of Gasparri, attention is drawn to the analysis of the law as reported in one of the more recently published decisions: "If the seminal fluid contains only dead sperms or infertile ones or defective ones or very few or none at all, the act can still be *per se aptus ad generationem* provided the *vasa deferentia* remain open and unoccluded and provided there is present in the ejaculation some testicular component, so that it might be said of the ejaculate that it is *elaboratum in testiculis.*"

There are many modern authors of great note, whose opinions on canonical questions are highly respected, who have accepted, developed and propounded the classical opinion of Cardinal Gasparri: among these can be numbered Ferrares, Wernz, Gasparri, De Smet, Cappello, DeBecker, Marc-Gesterman, Wouters, Tanquerey, O-

jetti, Wernz-Vidal, Merkelbach, Chelodi, Bucceroni, Ubach.

In more recent times, the Supreme Pontiff, Pope Pius XII, in an allocution to the Geneticists on September 7, 1953 and to the 26th Convention of the Italian Association of Urologists on October 8, 1953, shows definite tendency towards supporting the Gasparri opinion, as he referred to "definitely obstructed *vasa deferentia*."

The constant and unchanged jurisprudence of the Sacred Roman Rota more than forty years and the apparent adoption of this jurisprudence by two recent Popes give great stature and probability to the interpretation of Gasparri at the present time.

In view of this interpretation that *verum semen* be manufactured in the testicles, the following conditions would constitute impotency: complete absence or atrophy of both testicles, undeveloped testicles, double vasectomy, any obstruction of the *vas deferens*, complete occlusion of both epididymi caused by bilateral epididymitis, bilateral orchitis, blenorraghia, or other inflammatory diseases.

The adherents of the Gasparri opinion, although they require in the ejaculate, semen that has been manufactured in the testicles, do not demand that spermatozoa be present in the semen, because the presence or absence of spermatozoa refer only to fertility or sterility and have no reference to potency or impotency.

In summarizing the classical opinion, it is evident that for male potency there is required a penis, which is capable of being erected and of being sustained in erection until the vagina has been penetrated; at least one healthy, functioning testicle, which will manufacture its proper semen, even though the semen is devoid of all spermatozoa; an uninterrupted and unobstructed passage from the testicles to the urethral orifice and the ability to deposit within the female vagina the testicular fluid thus emitted and expressed.

The second opinion, which we might term the modern opinion, has reached its prominence in the last thirty-five years of canonical literature. Its principal arguments are that Gasparri, the author of the classical opinion, did not intentionally and purposefully conclude that true semen must be elaborated in the testicles; that the authorities quoted by Gasparri made no mention of the necessity of a testicular component in the ejaculate; that the *Cum Frequenter* of the sixteenth century was written at a time when the function of the testicles was not clearly known, the source of the male ejaculate was not understood and the endocrine process of the testicles had not been discovered; that the classical opinion demands too much in a situation where the law is attempting to set a minimum standard for qualification for marriage; and finally, that the condition of impotency, which flows from the natural law, and not from any positive legislation, should be easily discernible and should not have to depend for its detection upon microscopic evidence and involved medical procedures, which have only recently been perfected.

The supporters of this modern opinion are quick to show that the term *verum semen,* as found in the Bull of Pope Sixtus V, has been used by all canonists since that time but no one from 1587 to 1903 ever described it as being elaborated in the testicles. They point to the article on Impotence in Mignés *Encyclopedie Theologique* (Vol. 31, col. 1261), which summarizes the canonical literature on this particular subject up to 1849 and show that no author ever referred to *verum semen* as being manufactured in the testicles. They mention that this understanding was not had until Cardinal Gasparri employed these now famous words in his edition of 1903. They very properly inquire of the validity of marriages contracted in all the decades and centuries before 1903 and state that if an impediment is based on the natural law, it has been in effect from the very beginning, did not come into existence at any recent time, should be completely understood at all times and should be known by common observation, which is available to all peoples.

Those who have embraced the new theory argue that Sanchez, upon whom Gasparri based his opinion, never mentioned or inferred that true semen must be elaborated in the testicles. He did say that old men emit a semen of the same kind as fertile semen but only *per accidens* do they fail to generate children. Sanchez, in arguing against the validity of eunuch marriages, considers the objection that those, who have been deprived of both testicles, have as much a right to marry as old men, since the latter cannot emit a fertile semen and cannot generate children. The author answers by saying that old men give off a semen which appears, both in quality and quantity, to be the same as that produced by any normal man; whereas the castrate gives off a liquid, which is sparse in quantity and thin and watery and essentially different from the ejaculate of a normal man. This is the reason why the person, deprived of both testicles, cannot validly marry because, by common observation, he is different from the normal man.

Enriquez, in his writings, conjectured that a eunuch, who could produce *verum semen,* could marry in virtue of the natural law but would be estopped from marrying by reason of the positive legislation of the *Cum Frequenter.* Sanchez denied this conclusion because he said that such an hypothesis was impossible and therefore, Pope Sixtus V was justified in making the universial principle that eunuchs, lacking both testicles, could not validly marry.

Nowhere in his writings did Sanchez make any mention that *verum semen* should be elaborated in the testicles. He had every opportunity to do so, if that were his conviction, but he refrained from doing so. However, Sanchez did speak of the activity of the testicles, in terms that would refer to the present-day understanding of their endocrine function: "Eunuchs do have an erect penis and emit a watery substance, which is not true semen nor of the same constitution as semen. When the testicles are missing, there is no

arousal in the principal members. The three principal parts are the heart, the liver and the brain and these transmit impulses to the testicles, which can retain these impulses and excite the whole body. If the testicles are lacking, the impulses are not retained but vanish; the person is not excited, thus, such persons become frigid and inept to emit *verum semen.*"

It is evident and certain that Sanchez did not claim that true semen should be manufactured in the testicles but it is easy to see how Cardinal Gasparri might have obtained that impression because the presence of the testicles was required. However, it is more probable that Sanchez insisted on the presence of testicles more for their endocrinological function than as a source of the male ejaculate. In the middle of the twentieth century, when the sciences of endocrinology and urology have been perfected, it is easier for us to derive this conclusion than it would have been for Cardinal Gasparri in 1903.

In concluding this particular argument, the defenders of the modern opinion claim that from the *Cum Frequenter* and the writings of authors, contemporary to it, one cannot draw a cogent argument to favor the theory that *verum semen* must be elaborated in the testicles and this should be certain and conclusive, they say, if it is to establish an invalidating impediment.

The authors who have adopted the modern opinion discuss it principally with reference to the doubly vasectomized man and his consequent potency or impotency. Thus, they place a great deal of stress on the comparison between the castrate, who was prevented from marrying by the *Cum Frequenter,* and the doubly vasectomized man in relation to the semen emitted by both at the time of sexual intercourse.

Nowlan, in 1945, provided an excellent discussion on this particular point. He indicates that a great deal of the confusion on this general subject is due to the fact that medical science itself, upon which the canonists depend for medical information, did not understand the endocrine function of the testes until relatively recently and this lack of knowledge has accounted for many of the errors in decades and centuries past in regard to the effects of a vasectomy operation.

Ferreres, a renowned canonist, published a work on double vasectomy in 1913. At that time, very little was known of the endocrine function of the testicles and only scant information was had of the effects of a vasectomy operation, which was then in its early days of perfection. Ferreres quoted a single case which was presented to Eschbach by an anonymous doctor, who reported that ten months after a vasectomy operation, the patient had all the appearances of a castrate. Since this was the only medical testimony that Ferreres could find it is not to be wondered at that time this author likened the doubly vasectomized man to the castrate and drew the obvious conclusion that, since eunuchs could not

marry, neither could the man who had suffered a double vasectomy and this condition would constitute an invalidating impediment.

However, since that time thousands of double vasectomy operations have been performed and there is no evidence to warrant the judgment that these operations produce any emasculating effects. Also: modern endocrinology has verfied that virility and secondary male characteristics are controlled entirely by the minute secretions which pass directly into the central bloodstream from the interstitial cells of the testicles rather than by the sperm-producing cells, as was previously thought. This latter theory was responsible for the previous opinion that a double vasectomy operation would cause profound emasculating effects. As can be readily seen, the opinions of canonists on medical subjects will always depend on the medical information available at the time and if this information is found at a later date to be erroneous, then it must be expected that the canonical conclusions, based on it, will also be erroneous.

Because the doubly vasectomized man was thought to be equivalent to a castrate, Cappello, Wernz-Vidal, Gasparri and Ferreres considered double vasectomy to be an important condition. However, present day urology points out several important differences between these two classes. First, whereas a castrate can only emit a small quantity of thin, watery fluid, the doubly vasectomized man deposits an ejaculate of the same quantity and of the same viscosity as a normal man. On the one hand, there is a noticeable difference between the fluid emitted by a castrate and by a man who had submitted to double vasectomy operation and this is readily observable by the eye without any need of microscopic examination. On the other hand, there is no observable difference between the ejaculate of a doubly vasectomized man and a normal man, with the exception of the absence of spermatozoa, which can only be discovered by minute microscopic examination.

Those who favor the modern opinion feel that Pope Sixtus V forbade eunuchs to marry precisely because they could emit only a small amount of thin, watery fluid which differed both in quantity and quality from that of a normal man and, for this reason, they argue that doubly vasectomized men, who can emit a normal, viscous ejaculate, should not be equated with the castrate and should not be considered impotent.

Secondly, the vasectomy operation produces no apparent change in the sexual life of the patient. His virility is retained and he can still engage in sexual activity and derive pleasure and satisfaction from it. This cannot be said of a castrated male after the full effects of the condition have been realized.

Thirdly, contrary to the belief of Ferreres, no abnormal increase of sexual appetite is to be feared from the vasectomy operation. His theory was based on the reflection that a vasectomized man could not void a certain amount of semen because the channel from the testicles to the urethral orifice was

interrupted. This semen would tend to accumulate and increase the venereal appetite. However, modern medicine has disproved this theory.

For the above reasons, the authors, who champion this newer theory, believe that there is a vast difference between a castrate and a doubly vasectomized man and therefore, most probably, the Bull, *Cum Frequenter,* cannot be said to apply to the latter group. Thus, on this basis, double vasectomy most probably should not be considered as constituting an impotent condition.

Nowlan also advances the argument that the definition of the marital act as an act "which is per se apt for the procreation of children" is open to varying interpretation and since the meaning is doubtful and a difference of opinion exists as to what constitutes a normal marital act, the vasectomized man should be given the benefit of the doubt and not be considered certainly impotent. Also, this author refers to many reputable theologians who would allow persons who were castrated after a marriage to continue the exercise of the marital rights even though, by reason of the operation, they cannot perform an act which is "per se apt for generation." He argues that if an unmarried eunuch is forbidden to marry, because he cannot perform an apt marriage act, then a man, castrated after marriage, should be denied the exercise of his marriage rights for the same reason and he cannot be given the benefit of any doubt, since no doubt exists. The inference from this argmentation is that if persons, castrated after the marriage, are allowed to exercise marital rights, then doubly vasectomized persons should not be declared as certainly impotent, since their act is more apt than that of the castrate.

A further argument of this group is that the impediment of impotency has its source in natural law and binds all persons. Therefore, the determination of an impotent condition should be relatively easy for all and should be made on direct observation apart from involved surgical techniques and microscopic examination. Yet, the presence or absence of a testicular component in the ejaculate can only be ascertained by a minute microscopic examination and thus, it is difficult to understand how canonists can require a testicular component for potency. Especially does this argument have validity when one realizes that a woman, whose post-vaginal organs, uterus and ovaries, have been excised, has been considered to be potent, since the absence of these organs can be determined only by an examination and this was considered by canonical writers to be demanding too much for the verification of a natural law impediment.

The defenders of this modern opinion propose two further cogent arguments which are based on present-day physiological data. Father Ford, an outstanding moral theologian, provides a convincing summary of these two arguments in a recent article.

The first argument refers to the components of the normal ejacu-

late and states that the seminal fluid is composed of various elements produced by the testicles and epididymides, by the seminal vesicles, the prostate and urethral glands. The greatest part of the semen comes from the seminal vesicles, the prostate and the bulbo-urethral glands and not from the testicles and thus never passes through the *vasa deferentia.*

Quoting Doctor Victor M. Marshall of Cornell Medical Center, New York, Father Ford states that the testicles and epididymides provide about one-twentieth of the total ejaculate but this fraction includes the all-important spermatozoa, which all authors agree are not required for potency, because they refer specifically to fertility. If the spermatozoa are subtracted from the one-twentieth produced by the testicles and epididymides, there remains only a very small quantity of the liquid which passes through the *vasa deferentia* and which if it exists at all, serves only to facilitate the passage of the spermatozoa and can be detected only by minute microscopic examination of the ejaculate. Yet, those adopting the classical Gasparri opinion would make the presence or absence of this small quantity of liquid the determining factor in establishing the potency or impotency of a given individual, which appears untenable to those preferring the modern opinion.

Those who favor the classical opinion would insist on the presence of this minute quantity described as *"elaboratum in Testiculis."*

Father Ford introduces the second argument by saying that the ampulla of the *ductus deferens* act as a reservoir to hold the spermatozoa ready for the moment of orgasm and is situated at the end of the *vas deferens* farthest removed from the testicle. Again, quoting Doctor Marshall, he continues that it is unlikely that, in a given orgasm, any sperm travel all the way from the testicles but come from the terminal ends of the *vasa* because the distance from the testicles through the epididymides and *vasa deferentia* is about twenty feet and this would be too long for the sperm to travel in the few seconds that the orgasm lasts. Also, it is believed, according to Doyle, that the first thrust of the ejaculation contains the heaviest concentration of spermatozoa, and this would seem to indicate that, prior to orgasm, the spermatozoa are closer to the urethral orifice and do not travel all the way from the testicles.

If it is true that the sperm do not travel from the testicles at the time of orgasm and that the testicles do not, in fact, actively participate in the orgasm, then the followers of the Gasparri opinion would consider a doubly vasectomized man to be impotent for a reason that would make every man impotent, since the testicles, even of a normal man, do not contribute anything at the moment of orgasm.

It would appear that the sponsors of the Gasparri opinion could rebut this argument by stating that they have never argued that the semen had to be manufactured in the testicles and released by the testicles at the precise moment of

orgasm. They probably would accept the physiological data that the spermatozoa and other contents, produced by the testicles and epididymides, are preserved in the ampulla of the *ductus deferens* and would only insist that the semen, effused at the moment of orgasm, be elaborated at some time in the testicles.

In presenting the modern opinion and setting forth its arguments in full, it remains to refer to two Papal rescripts. On June 8, 1939, the Supreme Sacred Congregation of the Holy Office granted a sanation in a marriage which was invalid because it was contracted in the presence of a civil officer or minister and not in the presence of a Catholic priest. The man had submitted to a double vasectomy operation before the validation of the marriage and yet the sanation was granted by the Holy Office, which would indicate that this Congregation is not certain that double vasectomy induces impotence, since a sanation could never be granted in favor of a certainly impotent person.

The Bishop of Aachen, Germany on December 17, 1934 inquired of the Supreme Sacred Congregation of the Holy Office whether "a man, who has undergone a total and irreparable double vasectomy or some similar operation, which absolutely prevents communication with the testicles with the result that the discharge of sperm cannot be made in the natural manner, can be safely allowed to marry according to the norm laid down in Canon 1068 §2?" As mentioned previously, Canon 1068 §2 states that "if the impediment of impotency is doubtful, whether the doubt be one of law or fact, the marriage is not to be prohibited."

The Holy Office replied on February 16, 1935 that "in the case of such sterilization which was imposed by an infamous law, the marriage, according to the prescripts of Canon 1068, §2, was not to be prohibited."

The Sacred Roman Rota recognized the validity of this reply but interpreted it as expressing a doubt of fact — that the Holy Office doubted the fact of the permanency of the vasectomy — even though the original petition stated clearly that the condition was permanent and that the surgery could not be reversed. This reply has not changed the jurisprudence of the Sacred Roman Rota, which refuses to admit a doubt of law in the case of those unable to deposit a *"semen elaboratum in testiculis."*

By reason of the above-described arguments, which are considered to be reasonable and to have probability, many renowned canonists and moral theologians are of the opinion that it has not been proved with certainty that the semen, emitted at the time of the orgasm, must be elaborated and manufactured in the testicles and that the ejaculate must contain a testicular component. Among the more noteworthy and better canonists and theologians, who have adopted this modern opinion, can be mentioned: Jorio, Noldin-Schmitt, Arend, Woywood, Donovan, Viglino,

Vermeersch, Grosam, Gemelli, Laboure, LaRochelle and Fink, Ryan, Clifford, Chretien, Piscetta-Gennaro, Regatillo, Prümmer, Payen, Vermeersch-Creusen, McCarthy, Connell, Kelly, Mahony, Bender, Fanfani, Lanza-Palazzini, Ford.

In at least one decision, the Sacred Roman Rota has referred to the modern opinion and has stated: "In the past twenty years, some authors have understood *verum semen* simply as that liquid which is ejaculated during copula without regard to the particular gland from which the ejaculate comes, and they have denied that for the essence of perfect copula it is required that at least some part of the ejaculate come from the testicles. The Sacred Roman Rota could not consider this new doctrine as probable and so it has not applied it in its decisions."

In conclusion, the modern opinion would hold that, for male potency, there is required a normally constructed penis, which is capable of being erected and of being sustained in an erectile state until the vagina has been penetrated; ordinarily at least one functioning testicle which will produce the androgen, which, on being released into the blood stream, will provide the necessary stimuli to effect an erection and a semination constituted by the secretions of the seminal vesicles, prostate gland, Cowper's gland and the bulbo-urethral glands. This opinion differs from the Gasparri opinion in that it would not require any testicular component in the ejaculate and it would not demand an uninterrupted and unobstructed passage from the testicles to the urethral orifice.

Although it has never been previously discussed in the canonical literature, the present writers are convinced that since the modern opinion requires the presence of one healthy testicle solely for its androgenic effect, then it is logical to advance one step further and state that if the androgenic effect can be procured by the administration of a synthetic hormone apart from and even in the absence of both testicles, with the same effects being achieved as by natural androgen, secreted by the testicles, then it would appear that the presence of even one functioning testicle should not be required for potency.

As will be mentioned in the medical section of this study, there is a sound physiological basis for the opinion that if a male, who had normal testicular secretions up to and after the age of puberty, should be deprived of both testicles in a bilateral orchiectomy at a later time, the natural androgen function of the testicles can, in many cases, be supplied by the continuous administration of a synthetic hormone with equally favorable results.

With this continuous androgen therapy, the secondary male sex characteristics are maintained and no emasculating tendencies are noted, the libido of the individual is not changed, the ability to experience and sustain a normal erection continues provided there is no psychic trauma, and the ejaculate would have normal viscosity, be of usual quantity and, to all

appearances, would not differ from the ejaculate of a doubly vasectomized man or a normal man.

For these reasons, the present writers feel that, if the androgen therapy works beneficially, the bilaterally orchiectomized male, in the circumstances mentioned above, differs considerably from the eunuchs and castrates described by Pope Sixtus V and, therefore should not be classified as impotent. Also, as long as a testicular component is not required in the ejaculate, these are just as capable of participating in sexual relations as normal individuals.

Since this synthetic hormonal therapy does not achieve the above-mentioned results in each and every case, it is clear that each individual situation must be resolved on its own merits. A bilaterally orchiectomized man cannot be prevented from marrying until it is certain that the androgen therapy will not be productive of good results. If there remains any doubt as to its effectiveness or the full period of time for testing its efficiency has not elapsed, then the man should be allowed to marry under terms of Canon 1068 §2. In regard to a marriage already contracted, the failure of the androgen therapy must be certain before it can be declared null and void.

The arguments, proposed by the defenders of the modern opinion, have cogency and intrinsic probability, it would seem, and the renowned canonists and moral theologians, who have embraced this opinion, give extrinsic probability to it. Thus, it is argued that if this minority opinion has both intrinsic and extrinsic probability, the Gasparri opinion cannot be called certain and both opinions should be termed probable, neither one more probable than the other. It would appear, to the present writers, that with two probable opinions, dealing with the semination required in copula, a doubt of law exists and in regard to a marriage to be contracted, Canon 1068 §2 should be invoked, which states: "If the impediment of impotency is doubtful, whether the doubt be one of law or of fact, the marriage is not to be prohibited" and in regard to a marriage already contracted, Canon 1014 should be invoked, which legislates: "Marriage enjoys the favor of the law; therefore, in doubt, the validity of the marriage should be sustained, until the contrary is proved."

Father Ford conducted a private poll among ten distinguished canonists and theologians in Rome. All of them are professors in Roman Universities, authors of note, and members of the Roman Congregations and Tribunals and because of this background, they would be familiar with the problem and also in a position to have private knowledge of how the Church's officials evaluate this modern opinion and whether or not the various Congregations and Tribunals might ever adopt it in adjudicating cases.

These authorities were asked if the opinion is probable and safe in practice, which states that a man, who underwent a double vasectomy operation prior to mar-

riage, which could not be repaired and was permanent, was not certainly impotent.

Four replied that this opinion was probable and safe in practice; five answered that it was not probable or safe in practice and one indicated that a categorical answer could not be given.

These same officials were asked if such a man, as previously described, had already contracted marriage and the validity of the marriage were being challenged, could the Judges of the Diocesan Tribunal decree that the nullity of the marriage had not been proved despite the jurisprudence of the Rota.

Five replied that they could so decree; one said they could so decree but should not; one answered that they could not make this finding; one declared that the judges should follow their conscience and two did not give a direct answer.

No one of those interrogated knew of any present tendency in the Sacred Rota to change its jurisprudence and adopt the modern opinion.

As to the allocutions of Pope Pius XII to the Geneticists on September 7, 1953 and to the Urologists on October 8, 1953, seven stated that the Holy Father left the question of double vasectomy and its possibly invalidating effects open for future discussion; one replied that the Pope did not condemn the modern opinion; one judged that the Pope considered the modern opinion only dubiously probable; one did not answer.

Father Ford also inquired of nine professors of moral theology and canon law in American Seminaries and all of them believed the modern opinion to be probable and safe in practice.

From the above, one thing is certain: a great difference of opinion still exists among the outstanding canonists of the world, even at the present time and this confusion will not be clarified until the matter is definitely settled by an official interpretation and decision of a competent Roman authority. Until that comes, it would appear that in adjudicating a specific case, the canonist, depending upon his convictions and the dictates of his own conscience, could apply the Gasparri opinion or the modern opinion, since both would appear to be probable, or consider a doubt of law to exist and apply Canon 1068 §2 in regard to marriages to be contracted and Canon 1014 in reference to marriages already contracted, the validity of which are being challenged.

For the completeness of this study, a brief reference should be made to the condition of hermaphroditism. Sanchez concluded that an hermaphrodite, in whom one sex was prevalent, could marry according to the prevailing sex but if that person were to marry according to the other sex. the marriage would be invalid by natural law because the union would be between two members of the same sex. This judgment was accepted and confirmed by the writings of Barbosa, Pirhing and Reiffenstuel.

Schmalzgrueber agreed to the validity of a marriage, contracted according to the prevalent sex; in

discussing the situation where a person marries according to the sex which is not prevalent, he distinguishes by saying that if the person is not potent to copulate according to the non-prevailing sex, the marriage is clearly invalid, but if he is potent to copulate, the marriage is valid, since a person who is potent to copulate according to a specific sex cannot be prevented from marrying as long as the two sexes are represented in the union.

Sanchez reports that, before his era, it was judged that, if neither sex prevailed, the person could not marry because he was both male and female at one and the same time and since such a condition was an impediment to sacred orders and religious profession, it should also be an impediment to marriage.

However, Sanchez and his followers declared that such a person must choose which sex according to which he wishes to marry and then he should go before an ecclesiastical judge to take an oath that he will never marry according to a sex other than the one he has chosen. Reiffenstual adds the note that if this individual, on the death of his spouse, remarries according to the sex he has renounced, the second marriage would be valid but illicit.

The Sacred Congregation of the Council handed down two important decisions in regard to hermaphrodites. The first was issued on December 17, 1859 and declared a marriage invalid because an individual had married as a female when the male sex was more prevalent and thus there was a union between two persons of the same sex. The second was issued on August 18, 1888 and concerned a marriage in which the husband declared the sex of his "wife" was uncertain. In all, she was examined by eight doctors and the majority of these decided that the individual pertained rather to the male sex and was unable to consummate the marriage as a female. Since this condition existed before the marriage, the union was declared invalid.

In recent times, Gasparri, Noldin and Cappello discussed the problem of hermaphroditism. They divided hermaphrodites into three distinct classifications: the perfect, the imperfect and the apparent hermaphrodite.

Perfect hermaphrodites are those who have the organs of both sexes and, at will, can act as man or as a woman in the act of marital relations. When the laws of physiology are considered, it becomes apparent that a perfect hermaphrodite cannot exist, unless it were to be posited that one complete person could be superimposed upon another complete person, since the external and internal organism of a man is completely different from the organism of a woman.

Imperfect hermaphrodites are persons of doubtful sex as they are neither true men nor true women. Their sexual organs are so formed that the organs of both sexes can be found. Even doctors have difficulty in knowing the true sex. Such persons are usually not capable of performing the conjugal

act since they can function neither as a man or as a woman. Because such anomalies are congenital and irreversible, it is clear that the diriment impediment of impotency would exist, which would prohibit a contemplated marriage from taking place or invalidate a union which has already been contracted.

Apparent hermaphrodites are individuals who seem to combine both sexes but who in reality are either men or women. They have a determined sex and, in addition to their proper organs, they seem to have or, in fact do have, some organs of the other sex, e.g. a man might be found with a uterus or an ovary; a woman might have a male testicle. In these cases, the testimony of qualified doctors is to be sought for the determination of the proper sex and the Ordinary of the Diocese is to be consulted before such a marriage can be arranged or be solemnized. Since apparent hermaphrodites can usually function normally in their determined sex, their condition would not be one of impotency and they can validly and licitly marry.

Conclusions

1) An impotent condition, whether on the part of the man or on the part of the woman, whether absolute or relative, which has certainly been proved to have been antecedent and permanent, constitutes a diriment impediment, with basis in the natural law, and prohibits a marriage to be contracted and nullifies a marriage that has already been contracted.

2) An impotent condition will be considered antecedent if it has been proved to have been congenital or if the surgery, or accident, which accounted for it, antedated the marriage in question.

3) An impotent condition will be judged permanent, if absolutely no cure or remedy exists or if an actual cure was considered to have been effected by miraculous intervention rather than by natural means or if an existing remedy is judged to be illicit, immoral or sinful by reason of the means employed, or if it presents a danger to the life of the patient. The availability of a remedy must be judged on a relative rather than on an absolute basis, taking into consideration how advanced and modern is the medical and surgical practice in the area where the patient resides. If a remedy is readily available but the impotent person refuses to submit to the required surgery or therapy and the impotency persists, the condition must still be judged to be temporary and not permanent. However, in such an eventuality, the other party might seek a dissolution of the marriage on the ground of non-consummation. Because medical science, through experimentation and research, is making rapid strides in conquering and finding cures for many illnesses, it is very possible that an impotent condition, considered permanent today, might be thought only temporary in the years to come and thus that which might prohibit or invalidate a marriage today will not be considered an impediment in the future. If a doubt arises as to the temporary or permanent nature of an impotent condition, the impediment of

impotency cannot be said to be present and, therefore, a contemplated marriage cannot be prohibited or a contracted marriage cannot be invalidated but the possibility remains of having a marriage dissolved on the basis of non-consummation.

4) It is unanimously accepted that male potency requires the presence of a normally constructed and developed male organ, which is capable of being erected and of being sustained in erection long enough to penetrate the female vagina and to seminate within it.

5) What constitutes proper semination is a matter of controversy at the present time. The followers of Cardinal Gasparri demand that a testicular component be contained in the ejaculate and therefore, in addition to the above-mentioned requirements, there should also be present at least one healthy testicle, which will elaborate some proper liquid over and above the spermatozoa and this liquid should pass through an uninterrupted passage from the testicle through the *vas deferens* and seminal vesicles to the urethral os and ultimately be deposited within the vagina of the woman at the moment of ejaculation. The devotees of the modern opinion would not demand any testicular component in the ejaculate or an uninterrupted passage from the testicles to the urethra and would require only a satiative copula to be effected by a semination from the seminal vesicles, prostate gland, Cowper's gland and the bulbo-urethral glands. Those favoring this opinion would usually insist on the presence of at least one healthy testicle, which, by its elaboration of androgen hormone, would account for the erection of the male organ. However, the present writers feel that if an erection can be experienced and sustained by maintaining the proper androgen level through the administration of a synthetic hormone in a male who had properly developed testicles up to puberty, then this modern theory should not require the presence of even one healthy testicle in those instances. Since synthetic androgen therapy is not effective in every instance, each case must be studied individually and decided on its own merits.

6) Since the Gasparri opinion and the modern opinion both enjoy probability, intrinsically and extrinsically, either can be preferred or invoked or there remains a third possibility, in the opinion of the present writers, that, because certainty does not exist on either side, a judgment can be made that a positive and probable doubt of law exists. Because of this doubt of law, in instances where at least one functioning testicle is not had or a testicular component is not present in the ejaculate because of the absence of the testicles or because of some irreversible obstruction along the passage, leading from the testicle to the urethral orifice, an anticipated marriage cannot be impeded or a contracted marriage cannot be declared null.

7) Although some few medical anomalies can be readily considered as impotent conditions and, because of their permanent nature, can be judged to constitute the

impediment of impotency as well, yet, in most instances, an unqualified and categorical answer cannot be given but rather the individual, specific symptoms and factors of each case must be studied and analyzed before it can be determined that a given condition is one of impotency or that an impotent condition is permanent.

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FEDERATION EXECUTIVE BOARD MEETING SCHEDULED

The Executive Board of the Federation of Catholic Physicians' Guilds will meet December 6-7, 1958. Time: 9:30 a. m. Place: Leamington Hotel, Minneapolis, Minnesota.

The officers of the Federation and one delegate from each active constituent Guild constituting the Board will conduct business.

Roll Call

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